STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152 NAME OF PROVIDER OR SUPPLIER		TIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING STREET	(X3) DATE SURVEY COMPLETED 02/28/2013	
MONTICE	ELLO ASSISTED LIVING	AND HEALTHCARE		I MAIN ST ICELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code R State Licensure Surve the Indiana State Depa accordance with 42 C Survey Date: 02/28/1 Facility Number: 000 Provider Number: 15 AIM Number: 10028 Surveyor: Bridget Br Code Specialist At this Life Safety Co Monticello Assisted L Healthcare was found with Requirements fo Medicare/Medicaid, 4 483.70(a), Life Safety 2000 edition of the Na Protection Association Safety Code (LSC), C Health Care Occupand 16.2. This fully sprinklered one story building of construction with a pa two story building det V (111) construction.	ecertification and by was conducted by artment of Health in FR 483.70(a). 3 0072 5152 7440 own, Life Safety de survey, diving and anot in compliance or Participation in the	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		01	COMPLETED 02/28/2013)
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CO MAIN ST CELLO, IN 47960	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE COI	(X5) MPLETION DATE
	construction Types. The facility has a fire alarm system with hard wired smoke detection in the basement, corridors and in spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity for 147 residents and had a census of 97 at the time of this survey. All areas accessible to residents are sprinklered. Areas providing facility services were sprinklered except a detached shed and a building used for storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/05/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 2 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY O1 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUII	LDING	01	02/28/2	
		155152	B. WIN			02/20/	2013
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
MONTICE	ELLO ASSISTED L	IVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010018 SS=E	than required end openings, exits, or substantial doors of 13/4 inch solid-be capable of resisting minutes. Doors in only required to resmoke. There is closing of the door with a means suit closed. Dutch do permitted. 19.3 Roller latches are regulations in all leased on observe facility failed to corridor opening compartments confirme. This definitions are staff, visitors and	corridor openings in other closures of vertical or hazardous areas are a such as those constructed conded core wood, or any fire for at least 20 an sprinklered buildings are easist the passage of no impediment to the core. Doors are provided cable for keeping the door cors meeting 19.3.6.3.6 are 3.6.3 are prohibited by CMS and the care facilities. The ation and interview, the ensure doors protecting as in 3 of 11 smoke could latch into the door cient practice affects and second floor	K01	10018	K 018 It is the practice of this provide ensure that doors protecting corridor openings latch into the door frame.		03/30/2013
	Findings include	:			What corrective action(s) will be accomplished for those residents found to have been		
	Based on observ	ation with the			affected by the deficient practice?		
	maintenance dire	ector on 02/28/13			practice:		
	between 11:30 a	.m. and 2:30 p.m., the					
	double door sets	protecting openings to					
		the storage room near			The double door set protecting		
		est and second floor ice			the openings to the corridors for the storage room near room 25		
	-	and two door sets to the			the first and second floor ice	JU,	
		room each had one			machine rooms and the two do	oor	
					sets to the first floor dining roo		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 3 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155152	B. WING		02/28/2013
NAME OF B	PROVIDER OR SUPPLIEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	KOVIDEK OK SUFFLIEI		1120 N	I MAIN ST	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE	MONT	ICELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
inactive leaf with a manual flush bolt to				have been changed to	
	secure the inacti	ve leaf into the door		automatically latch into the do	or
	frame. Unless the	he inactive door leaf was		frame.	
	manually latched	d in these door sets,			
	_	s secured tightly into the			
		e maintenance director			
		t the time of observations,			
	_	not latch automatically		How will you identify other	
	into the door fra	·		residents having the potentia	ai
	into the door ma	me.		to be affected by the same deficient practice and what	
	2.1.10(1.)			corrective action will be take	n?
	3.1-19(b)				
				All residents have the potentia	I to
				be affected by the alleged	
				deficient practice.	
				All double door sets automatically	ally
				latch into the door frames.	
				What measures will be put in	to
				place or what systemic	
				changes you will make to	
				ensure that the deficient	
				practice does not recur?	
				The Maintenance Supervisor	or
				his designee will check the do	
				monthly with the monthly fire of	drill
				to ensure they automatically la	atch
				into the frame.	
				The Maintenance Supervisor	or
				The Maintenance Supervisor	<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 4 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	01	COMPLETED 02/28/2013		
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				his designee is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place. The preventative maintenance book will be reviewed related the checking doors protecting corridor openings to ensure the latch into the door frame during the monthly CQI meeting by the complex considerable and the constant of	he eur, e? e log to ey g		
				Interdisciplinary team. Compliance Date: March 30, 2013			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 5 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLE	
		155152	B. WIN			02/28/2	.013
NAME OF D	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1120 N	MAIN ST		
MONTICI	ELLO ASSISTED LI	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010025	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
SS=E		re constructed to provide at					
		our fire resistance rating in					
		8.3. Smoke barriers may					
		trium wall. Windows are					
		rated glazing or by wired					
		steel frames. A minimum ompartments are provided					
		mpers are not required in					
	duct penetrations of smoke barriers in fully ducted heating, ventilating, and air						
		ems. 19.3.7.3, 19.3.7.5,					
	19.1.6.3, 19.1.6.4		17.01	10025			02/20/2012
		ation and interview, the	KU	10025	K 025		03/30/2013
	_	ensure smoke barriers			K 025		
	_	moke compartments			It is the practice of this provide	er to	
		to provide the 1/2 hour			ensure that smoke barriers are maintained to provide the 1/2		
		e of the smoke barrier.					
	LSC 8.3.2 requir	es smoke barriers shall			hour smoke resistance of the		
	be continuous fro	om an outside wall to an			smoke barrier.		
	outside wall, from	m a floor to a floor, from					
	a smoke barrier t	to a smoke barrier or a					
	combination then	reof. Such barriers shall			What corrective action(s) will	1	
	be continuous th	rough all concealed			be accomplished for those		
	spaces, such as the	hose found above a			residents found to have been	¹	
	ceiling including	interstitial spaces. LSC			affected by the deficient practice?		
		equires the passage of			p. 400000		
		materials such as pipe,					
		be protected so the space					
		etrating item and the			The 2 West smoke barrier, th		
	_	all be filled with a			North smoke barrier, the 1 Nor smoke barrier, the 1 West smo		
		of maintaining the			barrier and the dryer exhaust	//C	
	_	e of the smoke barrier or			ducts have all been repaired to	,	
		an approved device			ensure the smoke barriers are		
	-	specific purpose. This			maintained to provide the 1/2		
	•	e could affect visitors,			hour smoke resistance of the smoke barrier.		
	deficient practice	t could affect visitors,			SHORE DAILIEL.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 6 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155152	B. WIN	G		02/28/2013
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG		nore residents on the		TAG	DEFICIENCE!)	DATE
	second floor and the 1 north, 1 west, and					
	laundry smoke compartments.					
	Findings include:				How will you identify other residents having the potenti	al
	a. Based on observations with the maintenance director on 02/28/13 between 11:05 a.m. and 11:30 a.m., the 2				to be affected by the same	
					deficient practice and what	
					corrective action will be take	en?
	west smoke barr					
	penetrations of o					
	_	ceiling. The 2 north			All residents have the potentia	al to
	smoke barrier had one unsealed				be affected by the alleged deficient practice.	
	wire/cable penet	tration and a second				
	wire/cable penet	tration where a fire caulk			The Maintenance Supervisor	
	seal was incomp	lete resulting in a two			his designee has examined the smoke barrier areas in the fact	
	inch gap above t	the lay in ceiling. The			to ensure that smoke barriers	•
	maintenance dir	ector acknowledged at the			maintained to provide the 1/2	
	time of observat	ions, the smoke barrier			hour smoke resistance of the	
	was not properly	y sealed.			smoke barrier.	
		servation with the				
		ector on 02/28/13 at 1:00				
	_	smoke barrier had a six			What measures will be put in	nto
	_	ction of drywall missing			place or what systemic changes you will make to	
		e of the wall above the lay			ensure that the deficient	
	_	maintenance director			practice does not recur?	
	_	t the time of observation,				
		er was not properly sealed.				
		ervation with the			The Maintenance Supervisor	or
		ector on 02/28/13 at 1:00			his designee will monitor any	
	_	smoke barrier was		future contract modificati		, to
	_	ve the lay in ceiling.			involving over the ceiling work ensure that smoke barriers are	
		tuds were exposed			maintained to provide the 1/2	
	between corrido	r walls on the east side of			·	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155152	B. WIN	G		02/28/	2013
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER		1120 N MAIN ST				
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the smoke barrie	r above the lay in ceiling.			hour smoke resistance of the		
	A blackened, charred area was noted on one stud. The maintenance director said				smoke barrier. The Maintenance Supervisor or		
						or	
	at the time of ob	servations, the charred			his designee will review a smo		
	area was a result	of "someone braised the			barrier area monthly with the		
	pipe" located nex				preventative maintenance rour		
		ervation with the			to ensure that smoke barriers	are	
		ector on 02/28/13 at 2:17			maintained to provide the 1/2 hour smoke resistance of the		
	p.m., one inch gaps around two				smoke barrier.		
	commercial dryer exhaust ducts penetrating the ceiling smoke barrier			Sincing Salinois			
	between the laundry and attic behind				The Maintenance Supervisor of	or	
		vere sealed with a pink			his designee is responsible to ensure compliance.		
	-	n. The maintenance			choure compliance.		
		he time of observation,					
		ire resistant rated					
		/28/13 at 2:35 p.m., the			How the corrective action(s)		
	labeling for the f	foam reviewed with the			will be monitored to ensure t		
	maintenance dire	ector read, "Fire Block			deficient practice will not rec	ur,	
	Foam; Type V R	esidential; Danger:			i.e., what quality assurance program will be put into place?		
	Extremely flamn	nable." The maintenance					
	director acknowl	ledged at the time of					
		labeling review, the foam					
		opriate material for			The preventative maintenance	-	
	* *	ons behind the gas fueled			book will be reviewed related t	0	
	dryers.	ons benine the gas racica			ensuring smoke barriers are maintained to provide the 1/2		
	41 y 015.				hour smoke resistance of the		
	3.1-19(b)				smoke barrier during the mont	hly	
	J.1-19(U)				CQI meeting by the		
					Interdisciplinary team.		
					Compliance Date: March 30,		
					2013		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 8 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155152	B. WING			02/28/	2013
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
MONTICE	ELLO ASSISTED LI	IVING AND HEALTHCARE			CELLO, IN 47960		
				WONT	SEEES, 114 47 300		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010029 SS=E	NFPA 101 LIFE SAFETY CO One hour fire rate hour fire-rated do automatic fire ext accordance with a protects hazardou approved automas system option is useparated from or resisting partitions self-closing and in protective plates inches from the big permitted. 19.3 Based on observing facility failed to hazardous areas closed automatic the fire alarm system door tightly close practice affects with more residents in room. Findings include Based on observing maintenance directly p.m., the door self-close and did into the door frame with the door frame with the fire alarm system are residents in room.	ed construction (with % ors) or an approved inguishing system in 8.4.1 and/or 19.3.5.4 as areas. When the stic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are con-rated or field-applied that do not exceed 48 ottom of the door are 6.2.1 ation and interview, the ensure 1 of 12 doors to such as the kitchen cally or upon activation of stem. Furthermore, doors as are required to latch in when closed to keep the ed. This deficient visitors, staff and 30 or in the first floor dining	K01	0029	K 029 It is the practice of this provide ensure that doors to hazardous areas such as the kitchen closs automatically or upon activation of the fire alarm system. It is the practice of this provide ensure that doors to hazardous areas latch in the door frame when closed to keep the door tightly closed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	er to s e en er to s	03/30/2013
	the kitchen side	of the door. The			and the first floor dining room		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 9 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155152	B. WING		02/28/2013		
NAME OF F	PROVIDER OR SUPPLIER	3	STREET	ADDRESS, CITY, STATE, ZIP CODE			
			1120 N MAIN ST				
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE	MONTI	CELLO, IN 47960			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		ector acknowledged at the		closes automatically or upon			
	time of observat	tion, the door could not		activation of the fire alarm system. The door separating	the		
	close automatica	ally and latch into the		kitchen and the first floor dinin			
	door frame.			room latches when closed to			
				keep the door tightly closed.			
	3.1-19(b)						
				How will you identify other			
				residents having the potentia	al		
				to be affected by the same			
				deficient practice and what			
				corrective action will be take	n?		
				All residents have the potentia	l to		
				be affected by the alleged			
				deficient practice.			
				The Meintene C			
				The Maintenance Supervisor his designee has examined do			
				to hazardous areas to ensure	0015		
				they close automatically or up	on		
				activation of the fire alarm sys			
				and that they latch when close	ed to		
				keep the door tightly closed.			
				What measures will be put in	to		
				place or what systemic			
				changes you will make to			
				ensure that the deficient			
				practice does not recur?			
				The Maintenance Supervisor	or		
				his designee will monitor doors			
				-			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 10 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	01	COMPLETED			
		155152	B. WING		02/28/2013		
	PROVIDER OR SUPPLIER	VING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				hazardous areas during mont preventative maintenance rou to ensure they close automati or upon activation of the fire alarm system and that they la when closed to keep the door tightly closed.	inds ically tch		
				The Maintenance Supervisor his designee is responsible to ensure compliance.	l l		
				How the corrective action(s) will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into place	the cur,		
				The preventative maintenance book will be reviewed related ensuring doors to hazardous areas close automatically or upon activation of the fire alar system and that they latch who closed to keep the door tightly closed during the monthly CO meeting by the Interdisciplinate team.	rm nen V		
				Compliance Date: March 30, 2013			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 11 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155152	B. WIN			02/28/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MONTICI	ELLO ASSISTED LI	IVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN 47960				
					CLLEO, IN 47 900		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K010038	NFPA 101						
SS=E							
			K01	10038			03/30/2013
	facility failed to	ensure the accessibility			K 038		
	for 1 of 3 doors providing delayed exit egress to the outside from the second floor. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to				It is the practice of this provide	r to	
					ensure the accessibility for doo		
					providing delayed exit egress to		
					the outside from the second flo	or.	
	the release devic	e there shall be a readily			What corrective action(s) will		
		sign in letters not less			be accomplished for those		
	than 1 inch high	and not less than 1/8 inch			residents found to have been	1	
	in width on a cor	ntrasting background that			affected by the deficient practice?		
	reads as follows:	"PUSH UNTIL			pruotioo:		
	ALARM SOUN	DS DOOR CAN BE					
	OPENED IN 15	SECONDS." This					
	deficient practice	e could affect visitors,			The emergency exit stairway door near the second floor dini	ina	
	staff, and 36 resi	dents on the second floor.			room has a sign to notify	ing	
					occupants the door will open a	fter	
	Findings include	:			applying pressure to the door		
					latch for 15 seconds.		
	Based on observa						
	maintenance dire	ector on 02/28/13 at					
	12:00 p.m., the e	mergency exit stairway			How will you identify other		
	door near the sec	cond floor dining room			residents having the potentia	ıl	
	was identified by	the exit sign above the			to be affected by the same deficient practice and what		
	door. The exit d	oor provided access to			corrective action will be take	n?	
	the public way as	nd was equipped with an				=	
	electromagnetic	lock which released when					
	the door latch wa	as pushed for 15 seconds,			All regidents have the netertion	l to	
	a code was enter	ed into an adjacent			All residents have the potentia	ι ι υ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 12 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVI COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155152	A. BUII		01	02/28/2013	
		100102	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/2010	
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
		IVING AND HEALTHCARE			CELLO, IN 47960		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		CON	(X5)
TAG	`			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	MPLETION DATE
	keypad, or the fi	re alarm activated. The			be affected by the alleged		
		loor had no sign to notify			deficient practice.		
	occupants the do	or would open after			All emergency exit stairway do	ors	
	applying pressur	e to the door latch for 15			have been reviewed to ensure		
	seconds.				they have a sign to notify	4	
					occupants the door will open a applying pressure to the door	πer	
	3.1-19(b)				latch for 15 seconds.		
					What measures will be put in	to	
					place or what systemic		
					changes you will make to		
					ensure that the deficient		
					practice does not recur?		
					The Maintenance Commisses		
					The Maintenance Supervisor his designee will review	or	
					emergency exit doors monthly		
					with the preventative		
					maintenance rounds to ensure they have a sign to notify		
					occupants the door will open a	fter	
					applying pressure to the door		
					latch for 15 seconds.		
					The Maintenance Comments	.	
					The Maintenance Supervisor of his designee is responsible to)ľ	
					ensure compliance.		
					How the corrective action(s)		
					will be monitored to ensure t	ne	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 13 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	01	COMPLETED 02/28/2013
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
				deficient practice will not rec i.e., what quality assurance program will be put into plac	
				The preventative maintenance book will be reviewed related to checking emergency exit door ensure they have a sign to not occupants the door will open a applying pressure to the door latch for 15 seconds during the monthly CQI meeting by the Interdisciplinary team.	o s to ify ifter
				Compliance Date: March 30, 2013	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 14 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152 NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		ED 913			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	(X5) COMPLETION DATE
K010062 SS=F	NFPA 101 LIFE SAFETY CO Required automa continuously main condition and are periodically. 19 NFPA 25, 9.7.5 1. Based on obs the facility failed piping for 1 of 1 systems was main loads. NFPA 25 sprinkler piping to external loads resting on the pip This deficient pri occupants. Findings include Based on observe maintenance direct between 11:15 a sprinkler pipes a near the 2 west, barriers had cable them. The main acknowledged at the sprinkler pip hangers for the vi 3.1-19(b) 2. Based on obs	DDE STANDARD tic sprinkler systems are ntained in reliable operating inspected and tested 0.7.6, 4.6.12, NFPA 13, ervation and interview, It to ensure sprinkler automatic sprinkler intained free of external 1, 2-2.2.2 requires shall be not be subjected by materials either pe or hung from the pipe. actice affects all exterior on 02/28/13 Im. and 1:15 p.m., bove the lay in ceilings I west and I north smoke es and wires laying over tenance director the time of observations, es were being used as	KO	10062	It is the practice of this provide ensure that sprinkler piping for the automatic sprinkler system maintained free of external load. It is the practice of this provide ensure that sprinkler heads are free of paint. It is the practice this provider to ensure shower room sprinkler heads are free obstructions to spray patterns. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.The wiring near the 2 Wes West and 1 North smoke barrinas been removed from the sprinkler piping. 2.The sprinkler heads protecting closets in rooms 26 262, 147 and 155 are free of paint. 3.The shower curtains in the first and second floor shower	er to . n is ads. er to ee of . of t, 1 ers	03/30/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 15 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155152	B. WIN	G		02/28/2013
NAME OF I	PROVIDER OR SUPPLIER	· {			ADDRESS, CITY, STATE, ZIP CODE	
					MAIN ST	
	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	heads in 2 of 11 smoke compartments			1110	rooms have been replaced wit	
		nt. NFPA 25, 2-2.1.1			curtains that do not obstruct th	
	_	ers to be free of foreign			spray pattern of the sprinklers.	
		s paint. This deficient				
		staff, visitors and 20 or				
	-	n the 2 west and 1 north				
	smoke compartn	nents.			How will you identify other	
					residents having the potentia	al
	Findings include: to be affe deficient				to be affected by the same	
			deficient practice and what			
					corrective action will be take	n?
	between 11:00 a	.m. and 2:15 p.m., paint				
	was observed or	-			All residents have the potentia	Il to
		ts in rooms 260, 262, 147,			be affected by the alleged deficient practice.	
		aintenance director				
		t the time of observations,			1. The Maintenance	
	-	nds should not have had			Supervisor or his designee ha examined the sprinkler pipes	S
	paint on them.				above the ceiling to ensure no	,
	2.1.10(1.)				wiring is laying on them.	
	3.1-19(b)				2 The Maintenance	
	2 Paged on ale	arrection and interview			The Maintenance Supervisor or his designee ha	s
		d to ensure 2 of 2 shower			examined all sprinkler heads t	
		neads were free of			ensure they are free of paint.	
	_	pray patterns. NFPA 25,			3. The Maintenance	
		unacceptable obstructions			Supervisor or his designee ha	s
	_	shall be corrected.			examined all shower rooms to	
		3, Standard for the			ensure the curtains do not obstruct the spray pattern of the	
		prinkler Systems, in 5-5.6			sprinklers.	IC
		rance between sprinkler			'	
	-	ne top of storage should be				
		re. This deficient practice				
		re residents using the first				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI	PLETED 8/2013	
	ROVIDER OR SUPPLIER ELLO ASSISTED L	IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CO I MAIN ST ICELLO, IN 47960	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	between 11:45 a shower curtains floor shower roo eight inches from were protected by which could not curtain. The man acknowledged at the sprinkler hear	ation with the ector on 02/28/13 .m. and 2:15 p.m., in the first and second ms were hung from a rod in the ceiling. The rooms y a single sprinkler head cover the area behind the intenance director the time of observation, ds were less than the ce allowed between a		What measures will be place or what systemichanges you will makensure that the deficie practice does not recute the property of	Supervisor initor any ations in gwork to iping is irrnal loads int draining is irrnal loads in the irrnal loads in the irrnal loads irr	
				How the corrective ac will be monitored to e	nsure the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 02/28/2013		
	PROVIDER OR SUPPLIE	R IVING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
				i.e., what quality assurance program will be put into pla			
				The preventative book will be reviewed related to ensuring sprinkler piping is maintained of external loads, sprinkler he are free of paint, and shower room sprinkler heads are free obstructions to spray patters during the monthly CQI meet by the Interdisciplinary team. Compliance Date: March 30 2013	that I free eads e of		
				reviewed related to ensuring sprinkler piping is maintained of external loads, sprinkler he are free of paint, and shower room sprinkler heads are free obstructions to spray patters during the monthly CQI meet by the Interdisciplinary team. Compliance Date: March 36	that I free eads e of ting		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 18 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			LDING	ONSTRUCTION 01	(X3) DATE (COMPL 02/28 /	ETED	
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE	5 . Will	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K010064 SS=E	health care occup 9.7.4.1. 19.3.5. Based on observe facility failed to monthly check we portable fire exti- oxygen transfer a 10, the Standard Extinguishers, in extinguishers sha maintenance not- or when specificant monthly inspecti- defines maintenancheck" of the exti- to give maximum extinguisher will safely. NFPA 10 monthly, the data initials of the per- inspection shall to NFPA 10, 4-2.1 quick check an e- and will operate. could affect affec- more residents in	guishers are provided in all pancies in accordance with 6, NFPA 10 ation and interview, the ensure an annual and vas provided for 1 of 1 inguishers provided in the and storage room. NFPA for Portable Fire 4-4.1 requires all be subjected to more than one year apart ally indicated by a inguisher. It is intended in assurance the operate effectively and 0, 4-3.4.2 requires at least e of inspection and the reson performing the per ecorded. In addition defines inspection as a extinguisher is available. This deficient practice ext visitors, staff and 10 or in the adjacent corridor ical therapy room and	K0	10064	K 064 It is the practice of this provide ensure an annual and monthly check is provided for portable extinguishers. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The portable fire extinguisher the oxygen transfer and storage room has been checked to ensure it will operate effective and safely and the tag is up to date. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. All residents have the potential	/ fire I in ge ly h	03/30/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 19 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO A. BUILDING	01	COMPLETED
	155152	B. WING		02/28/2013
	ROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	maintenance director on 02/28/13 at 2:25 p.m., the service and inspection tag on the portable fire extinguisher in the oxygen		be affected by the alleged deficient practice.	
	storage and transfer room noted the last monthly check had been done 09/27/12 and the annual check done in October of 2011. The maintenance director said at the time of observation, the fire		The Maintenance Supervisor or his designee has checked all portable f extinguishers to ensure they will op effectively and safely and the tags a up to date.	erate are
	extinguisher should have been replaced by the fire extinguisher contractor in October 2012. He conceded his monthly checks had not included this fire extinguisher since September 2012.		What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	nto
	3.1-19(b)		All portable fire extinguishers are checked monthly and annually to er they will operate effectively and safe and the tags are up to date with mo preventative maintenance rounds.	ely nthly
			The Maintenance Supervisor his designee is responsible to ensure compliance.	
			How the corrective action(s) will be monitored to ensure deficient practice will not reci.e., what quality assurance program will be put into place	the cur,
			The preventative maintenance book will be reviewed related	_

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 20 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO	01	COMPI	
		100102	B. WING			12013
	PROVIDER OR SUPPLIED ELLO ASSISTED L	R IVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP COI MAIN ST CELLO, IN 47960	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE
				ensuring fire extinguished checked monthly to ensure operate effectively and so the tags are up to date of monthly CQI meeting by Interdisciplinary team.	ure they afely and luring the	
				Compliance Date: Marc 2013	h 30,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 21 of 31

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2013	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MONTICE	ELLO ASSISTED LI	VING AND HEALTHCARE			I MAIN ST ICELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
K010069	NFPA 101	LSC IDENTIFY ING INFORMATION)		TAG	DEFICIENCE!)		DATE
SS=E	LIFE SAFETY CO Cooking facilities accordance with 9 Based on observa facility failed to		K01	10069	K 069	or to	03/30/2013
	cooking appliance shall not be move rearranged withouthe fire extinguis	PA 96, 9.1.2.2 requires rese requiring protection ed, modified, or out prior reevaluation of hing system by the or servicing agent, unless	e e n		It is the practice of this provider to ensure that commercial cooking extinguishing systems are maintained.		
	otherwise allower fire extinguishing Cooking appliance and appliances are re	d by the design of the g system. Exception: ces moved to perform cleaning provided the turned to their original to cooking operations,			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?		
	and any disconne system nozzle att are reconnected i manufacturer's li deficient practice staff, and 20 or n	ected fire extinguishing tached to the appliances in accordance with the sted design manual. This e could affect 4 kitchen			The extinguishing system noz for the commercial gas range adjacent grill are directed to protect areas of the appliance which could be the source of a fire.	and s	
		ation of the commercial			How will you identify other residents having the potention to be affected by the same deficient practice and what corrective action will be taken		
	with the mainten 02/28/13 at 2:10	od protection system ance director on p.m., protection was not commercial gas range			All residents have the potential be affected by the alleged	al to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 22 of 31

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/28/2013
		155152	B. WING		02/28/2013
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	FLLO ASSISTED I	IVING AND HEALTHCARE		MAIN ST CELLO, IN 47960	
				T	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE
		ll by the hood fire		deficient practice.	
	, J	es. Three extinguishing		·	
	•	were in stalled at angles		The Maintenance Superviso	or or
	•	ted at the ten inch		his designee will audit the extinguishing systems nozzl	les
		elf located above the		with monthly preventative	
		maintenance director said		maintenance rounds to ensu	· ·
	* *	servation, a new range		they are directed to protect a of the appliances which cou	
		nad been installed and the		the source of a fire.	iu be
	_	ozzles replaced in this			
		agreed the nozzles did not			
		ected to protect areas of		What massures will be see	into
		which could be the source		What measures will be put place or what systemic	into
	of a fire.			changes you will make to	
				ensure that the deficient	
	3.1-19(b)			practice does not recur?	
				The Maintenance Superviso	or or
				his designee will audit the	
				extinguishing systems nozzl	les
				with monthly preventative maintenance rounds to ensu	Ire
				they are directed to protect	
				of the appliances which cou	
				the source of a fire.	
				The Maintenance Superviso	
				his designee is responsible ensure compliance.	IO
				choure compliance.	
				How the corrective action(e)
				will be monitored to ensure	· .
				deficient practice will not r	
				i.e., what quality assurance	
				program will be put into pla	ace?
			Ī	1	l l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 23 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF		IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	01	COMPLETED 02/28/2013
MONTICEL		VING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				The preventative maintenance book will be reviewed related to the extinguishing system nozz for the commercial gas range adjacent grill to ensure they are directed to protect areas of the appliances which could be the source of a fire during the monthly CQI meeting by the Interdisciplinary team. Compliance Date: March 30, 2013	o les and e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 24 of 31

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED	
		155152	B. WIN	G		02/28/	2013
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010147 SS=E	accordance with I Electrical Code. 9 1. Based on obse	nd equipment is in NFPA 70, National 0.1.2 ervation and interview,	K01	0147			03/30/2013
	_	I to ensure a wet location			K 147		
	with ground-faul (GFCI) protection NFPA 70, Articl Facilities, define care areas subject patients are present standing fluids of the work areas condition is intimistaff. NFPA 70, requires all recept equipment within location to have Moisture can red of the body, and more subject to find the state of the	nate to the patient or 517-20 Wet Locations, otacles and fixed in the area of the wet GFCI protection. In the contact resistance electrical insulation is failure. This deficient feet visitors, staff and 2			It is the practice of this provide ensure that wet locations are provided with ground-fault circuinterrupter (GFCI) protection against electric shock. It is the practice of this provide ensure that electrical wiring connections are maintained in safe operating condition which includes junction boxes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	er to a	
	Based on observe maintenance directly 12:45 p.m., the elbathroom serving located 18 inches	:			1.The electric outlet in the bathroom serving resident roo 158 been eliminated. 2.The junction box near the inverse has a covered junction box has been provided for the four wires near the 1 North smoke barrier. 3.Power strips are not used power nebulizers. Power strip are not used in conjunction with the bath in the power strip are not used in conjunction with the bath in	2 ver n ar to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 25 of 31

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A. BUII		LDING	01	COMPLETED	
		155152	B. WIN			02/28/201	3
NAME OF I	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WINE OF TROVIDER OR SOFTELER					MAIN ST		
MONTICELLO ASSISTED LIVING AND HEALTHCARE				MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OMPLETION
TAG				TAG	extension cords. Extension co	rdo	DATE
	protection to prevent electric shock. The maintenance director said at the time of				are not used in the facility.	nus	
					are not used in the lability.		
		re was no circuit panel					
		tlet and the outlet should					
	have had GFCI	protection.					
	3.1-19(b)				How will you identify other		
	3.1 17(0)				residents having the potentia	al	
	2 Rased on obs	servation and interview,			to be affected by the same deficient practice and what		
					corrective action will be take	n?	
	the facility failed to ensure 2 of 2 electrical wiring connections were				Corrective detion will be take		
	۱ -						
	maintained in a safe operating condition which included junction boxes. NFPA						
	1	,			All residents have the potentia	l to	
	70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be				be affected by the alleged deficient practice.		
	1 -				denoient practice.		
	1 ^	overs compatible with the			1.The Maintenance Supervis		
		ent practice could affect			or his designee has reviewed		
	•	d 30 or more residents in			wet locations to ensure they h ground-fault circuit interrupter	ave	
	1 ^	ments protected by the 2			(GFCI) protection against elec	tric	
	north and I nort	h smoke barriers.			shock.		
					2.The Maintenance Supervis	sor	
	Findings include	2.			or his designee has reviewed	_	
					junction boxes above the lay in the ceiling to ensure they have		
		ervation with the			covers compatible with the box		
		ector on 02/28/13 at			3.The Maintenance Supervis		
	1	nction box above the lay			or his designee routinely chec		
		ne 2 north smoke barrier			rooms for extension cords and		
		covered with multiple			replace as needed.		
	_	The maintenance director			The nurse staff were		
	said at the time	of observation, the box			re-inserviced to not use a pow	er	
	was so full it loo	oked as though the cover			strip to power a nebulizer by		
	would not have	fit and a larger junction			March 30, 2013.		
	box was needed						
	b. Based on obs	servation with the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 26 of 31

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	л ріп	LDING	01	COMPLETED		
		155152	B. WIN			02/28/2013		
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1120 N MAIN ST				
MONTICELLO ASSISTED LIVING AND HEALTHCARE				CELLO, IN 47960				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE		
	maintenance director on 02/28/13 at 1:12			What measures will be pu		ito		
	_	tions for four wires above			changes you will make to			
		near the 1 north smoke			ensure that the deficient			
	barrier were mad	de with wire nuts. No			practice does not recur?			
	junction box was	s used. The maintenance						
	director acknow	ledged at the time of						
	observation the	wires should have been			1 The Maintenance Superviso	ror		
	provided with a	covered box.			his designee will monitor wet	1 01		
					locations with monthly			
	3.1-19(b)				preventative rounds to ensure			
				they have ground-fault circu				
	3. Based on observation and interview,			interrupter (GFCI) protection				
		d to ensure 5 of 5 flexible			against electric shock.			
		used as a substitute for						
		he 1 west and 1 north						
		nents. NFPA 70, 1999			2. The Maintenance Supervis			
		400-8 requires, unless			or his designee will monitor an	у		
		nitted, flexible cords and			future contract modifications involving over the ceiling work	to		
		be used as a substitute for			ensure that junction boxes abo			
					the lay in the ceiling have cove			
		structure. This deficient			compatible with the boxes.			
	_	ffect visitors, staff, and 30						
		s in the 1 west and 1						
	north smoke con	npartments.			3. The Maintenance Superviso	or or		
					his designee routinely check			
	Findings include	:			rooms for extension cords and			
					replace as needed during mor	- I		
		ervation with the			preventative maintenance roul	nas.		
	maintenance director on 02/28/13 at 1:15							
	p.m., a power str	rip extension cord was						
	used to power a	nebulizer in room 161.			The Maintenance Supervisor	or		
	The maintenance	e director said at the time			his designee is responsible to			
	of observation th	ne practice was not			ensure compliance.			
	permitted.	_						
		ervation with the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 27 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	COMPLETED 02/28/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	COMPLETION COMPLETION
	maintenance director on 02/28/13 at 1:15 p.m., a power strip extension cord was piggybacked with an extension cord in room 164 to power a television and clock. The maintenance director said at the time of observation, the cord had been brought in by family members. c. Based on observation with the maintenance director on 02/28/13 at 1:25 p.m., an extension cord supplied power to Christmas tree lights in room 169 and a pink extension corn was in use in resident room 146. The maintenance director said at the time of observation, the residents had been provided with power strips, extension cords were not permitted. 3.1-19(b)	How the corrective action will be monitored to ensur deficient practice will not i.e., what quality assurance program will be put into pitch and the properties of the preventative maintenant book will be reviewed during monthly CQI meeting by the Interdisciplinary team. Compliance Date: March 3 2013	e the recur, e ace? nce log g the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 28 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				` ′	ATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 02		02	COMPLETED		
		155152	B. WIN	G		02/28/	2013
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST				
MONTIC	ELLO ASSISTED LI	IVING AND HEALTHCARE		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K020046 SS=E	duration is provid 19.2.9.1. Based on observe facility failed to emergency light compartments we 7.9.2.5 requires to emergency lights repeated automated deficient practices 10 or more resident	ation and interview, the ensure battery powered fixtures in 3 of 11 smoke ould operate. LSC pattery operated is shall be capable of tic operation. This is ecould visitors, staff and ents in the west center floor, and the laundry nents.	K02	20046	K 046 It is the practice of this provide ensure that each battery operatemergency lighting fixture operates as required. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	ated I	03/30/2013
	powered emerge illuminate when floor dining roor closet, in the sec the second floor corridor outside maintenance dire	ector on 02/28/13 .m. and 2:30 p.m., battery ncy lights failed to tested twice in the first n near the dietary storage ond floor corridor, and in medicine room in the the laundry. The ector said at the time of lid not know the lights			The emergency lighting fixture the first floor dining room near dietary storage closet, in the second floor corridor and in the second floor medicine room in corridor outside the laundry habeen tested and the batteries have been replaced. All fixture are working properly. How will you identify other residents having the potentiat to be affected by the same deficient practice and what	the e the ave	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 29 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155152	A. BUILDING B. WING	02	COMPLETED 02/28/2013		
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				All residents have the potential be affected by the alleged deficient practice. All battery operated emergence lighting fixtures have been test to appare they are working.	ıl to		
				to ensure they are working properly. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	ito		
				A monthly test of 30 seconds a an annual test of 90 minutes who be conducted on all emergence lighting fixtures with preventation maintenance rounds. Batteries will be changed routinely and no less than once year. The Maintenance Supervisor of the second seco	vill Ey ive e a		
				his designee will be responsib How the corrective action(s) will be monitored to ensure t	le.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet Page 30 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 02/28/2013
	PROVIDER OR SUPPLIER ELLO ASSISTED LIVING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
			deficient practice will not re i.e., what quality assurance program will be put into pla	
			The preventative maintenance book will be reviewed related ensuring all emergency lighting fixtures are working properly during the monthly CQI meet by the Interdisciplinary team.	to ng
			Compliance Date: March 30 2013),

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2XHN21

Facility ID: 000072

If continuation sheet

Page 31 of 31